



**Patient Medical History (may we discuss your Medical History with your physician) Yes No**

Physician \_\_\_\_\_ Office Phone# \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

	Yes	No		Yes	No
1. Are you Allergic to or have any reactions to the following?		had			
Local Anesthetics ( Novocain)	___	___	3. Are you under medical treatment?	___	___
Penicillin	___	___	4. Any surgeries within the last three months?	___	___
Sulfa Drugs	___	___	5. If you are taking any current medications please list _____		
Aspirin	___	___			
Any Metals (Nickel, Mercury)	___	___			
Latex Gloves	___	___			
Other _____					
2. Women only:					
a) Are you pregnant or think that you may be pregnant?	___	___	6. Do you use tobacco?	___	___
b) Are you nursing?	___	___	7. Have you ever taken Pen-Fen?	___	___
c) Are you taking any oral Contraceptives?	___	___			

8. Do you or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure?	___	___	Heart Disease?	___	___	Chest Pain?	___	___
Heart Attack?	___	___	Cardiac Pacemaker?	___	___	Stroke?	___	___
Rheumatic Fever?	___	___	Heart Murmur?	___	___	Tuberculosis?	___	___
Fainting/Seizures?	___	___	Anemia?	___	___	Radiation Therapy?	___	___
Asthma?	___	___	Emphysema?	___	___	Glaucoma?	___	___
Low Blood Pressure?	___	___	Cancer?	___	___	Liver Disease?	___	___
Epilepsy/Convulsions?	___	___	Arthritis?	___	___	Respiratory Problems?	___	___
Leukemia?	___	___	Joint Replacement	___	___	Mitral Valve Prolapse?	___	___
Diabetes?	___	___	or Implant?	___	___	Bleeding Disorder?	___	___
Kidney Disease?	___	___	Hepatitis/ Jaundice?	___	___	Stomach Troubles?	___	___
AIDS or HIV infection?	___	___	Sexually Transmitted Disease?	___	___	Other _____		

**Patient Dental History**

Name of previous Dentist and Location \_\_\_\_\_ Date of last examination \_\_\_\_\_

	Yes	No
1. Do you feel pain in any of your teeth? If yes, Area? _____	___	___
2. Have you had any head or neck injuries?	___	___
3. Do you have frequent headaches?	___	___
4. Do you have any jaw problems?	___	___
5. Would you like your smile improved?	___	___

**Authorization and Release**

The above questions have been accurately answered and I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Vasco to perform a diagnostic and necessary exam, x-rays, photographs and /or models. With my consent, I authorize Dr. Vasco to perform necessary dental procedures with or without anesthetic, pre-medication and/or sedation, which his judgment may indicate during treatment.

X \_\_\_\_\_  
Patient signature (or parent if minor) \_\_\_\_\_ Date \_\_\_\_\_

Doctors comments \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

